

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04960

Reg. Dist. No.

4973

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Wayne Tyres</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/49</u>
9. AGE (In years last birthday) <u>9</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School boy</u>	
11. BIRTHPLACE (State or foreign country) <u>Newark Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Sewell Tyres</u>		14. MOTHER'S MAIDEN NAME <u>Annah Mary Coard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-</u>	
17. INFORMANT <u>Annah Mary Coard</u>		Address <u>Berlin Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> 929.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Short</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chilly day - water cold</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stuffed into a deep hole while working in shallow water</u>	
20c. TIME OF INJURY Month, Day, Year <u>12/20</u> o. m. <u>4:44</u> p. m. <u>1959</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Travel - Md</u>	20f. (City or town) <u>Near Berlin</u> (County) <u>Worcester</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) <u>Berlin</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Kraus</u>	
ADDRESS <u>Salisbury Rd.</u>		DATE <u>APR 29 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04961

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4974

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leon</u> First <u>Clifton</u> Middle <u>Byres</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/48</u> 10 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Newark Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Sewall Byres</u>		14. MOTHER'S MAIDEN NAME <u>Annah Mary Coard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>23-3</u>	
17. INFORMANT <u>Annah Mary Coard</u> Address <u>Berlin Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.2</u> DUE TO <u>Accidental Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shallow water</u> (c) <u>Short</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chilly day - water cold</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stepped into a deep hole while wading in</u>	
20c. TIME OF INJURY Month <u>4</u> Day <u>24</u> Year <u>1959</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Gravel pit</u>		20f. (City or town) <u>Mar Berlin</u> (County) <u>Worcester</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Sartorius Sr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>evergreen</u>		22d. LOCATION (City, town, or county) <u>Berlin</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton B. Stewart</u> ADDRESS <u>Salesbury Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Krame</u> DATE <u>APR 29 '59</u>	
		24b. REGISTRAR'S SIGNATURE	

11881

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15 1904</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
OCCUPATION <i>Farmer</i>		MARITAL STATUS <i>Married</i>		EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASES PREEXISTING <i>None</i>		DISEASES ACQUIRED <i>None</i>	
SIGNATURE OF EXAMINER <i>J. H. Smith</i>		DATE <i>Jan 15 1904</i>		PLACE <i>Baltimore</i>		COUNTY <i>Harford</i>	

1

RECEIVED
JAN 15 1904
BALTIMORE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>Several years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur James Brown</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9b. AGE (In years last birthday) <u>66</u> yrs.	
10a. BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Undetermined</u>	
14. MOTHER'S MAIDEN NAME <u>Undetermined</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>225-09-7001</u>		17. INFORMANT <u>Mr. John W. Durbage - Berlin Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>823X Broken Neck & Head injury instant</u> DUE TO (b) <u>Auto Accident</u> DUE TO (c) <u>Loss of Control of his car</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Excessive Speed in driving</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Broken neck while traveling at rapid speed and control in a ditch</u>			
20b. DESCRIBE HOW INJURY OCCURRED (Enter only in Part I or Part II of Item 18.) <u>Highway Route 13</u>			
20c. TIME OF INJURY Month, Day, Year <u>4/18/59</u> Hour <u>3:25</u> a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/>			
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, 1205. (City or town) <u>Berlin</u> (County) <u>Worcester</u> (State) <u>Md</u>)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>		22d. LOCATION (City, town, or county) <u>Berlin Md</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Durbage Fun. Home</u>		ADDRESS <u>Berlin Md.</u>	
24a. REG'D BY REGISTRAR <u>DATE APR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4976

CERTIFICATE OF DEATH

04963

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Merrill</u> Middle <u>A.</u> Last <u>Lehesser</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 - 1895</u>
9. AGE (In years last birthday) <u>63 1/2</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Hallwood Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Lehesser</u>		14. MOTHER'S MAIDEN NAME <u>Annie Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Mae H. Lehesser</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unbalanced Cardio Respiratory Physiology</u> DUE TO (c) <u>Left Pneumectomy for Bronchogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>9 YRS</u> <u>9 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia & Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1949</u> , 19 <u>48</u> , to <u>APRIL 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>APRIL 5</u> , 19 <u>59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. LaMar</u>		ADDRESS (Street, city or town, state) <u>M.D. 104 Bay Street, Snow Hill, Md., 4-6-59</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M.D.</u>		104 Bay Street, Snow Hill, Md.	
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wheaton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Dennis</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Date of Registration	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G241 4-21-59 et

4977

CERTIFICATE OF DEATH

04964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Own home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>Franklin</u> Last <u>Evans</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27-1876</u>
9. AGE (In years last birthday) <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales</u>	
11. BIRTH PLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Franklin Evans</u>		14. MOTHER'S MAIDEN NAME <u>Clanor White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Francis H. Cherry</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Hypertrophic Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1948, to <u>April 12</u> , 1959, that I last saw the deceased alive on <u>April 12</u> , 1959, and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. B. La Mar</u>		ADDRESS (Street, city or town, state) <u>104 Bay St.</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>		DATE SIGNED <u>4-13-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bales Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne G. Ginn</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. BROWN		45		M		W		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JUN 10 1925		BALTIMORE, MD.	
FATHER		MOTHER		BORN		DIED		AGE		SEX	
JAMES M. BROWN		MARY J. BROWN		JAN 15 1880		JUN 10 1925		45		M	
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		DIVORCED	
HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED	
SIGNED BY		WITNESSED BY		DATE		PLACE		DATE		PLACE	
JAMES M. BROWN		MARY J. BROWN		JUN 10 1925		BALTIMORE, MD.		JUN 10 1925		BALTIMORE, MD.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04965

4971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belden Restorium				d. STREET ADDRESS RFD #2			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle R. Last FISHER				4. DATE OF DEATH Month April Day 3 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William J. Russell				14. MOTHER'S MAIDEN NAME Catherine Custis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Norwood W. Fisher, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Atherosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 2 1958 to Apr 3 1959 that I last saw the deceased alive on Mar 2 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Market Street DATE SIGNED Apr 3 59							
ACTUAL SIGNATURE N. E. Sartorius M.D.				PHYSICIAN'S NAME (Type) N. E. Sartorius, Sr. Pocomoke City, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-59		22c. NAME OF CEMETERY Liberty Cemetery		22d. LOCATION (City, town, or county) (State) Parksley, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Sedatow ADDRESS Pocomoke City, Md.				24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4978

CERTIFICATE OF DEATH

04966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
c. LENGTH OF STAY IN 1b <u>13 yrs</u>		d. STREET ADDRESS <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Hopkins</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28-1913</u>
9. AGE (In years last birthday) <u>45 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Latchery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Cricle, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William J. Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-32-9362</u>	
17. INFORMANT <u>Mrs. Mathilde D. Hopkins, Snow Hill, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>April 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>59</u> , and that death occurred at <u>3:00 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cohen</u>		DATE SIGNED <u>4/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Paul Cohen</u>		ADDRESS (Street, city or town, state) <u>Snow Hill MD</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>May 1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whispering Method</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Dennis</u>		ADDRESS <u>Snow Hill, MD</u>	
24a. REC'D BY REGISTRAR <u>MAY 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4979

CERTIFICATE OF DEATH

04967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>S.</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4 - 1866</u>
9. AGE (In years last birthday) <u>92</u> <u>3</u> <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Berlin, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Rodney</u>		14. MOTHER'S MAIDEN NAME <u>Atlanta Birch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Mary H. Townsend</u> Address <u>Snow Hill, md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS & MYO CARDITIS</u> DUE TO (c) <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>54</u> , to <u>April 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. LaMar</u>		DATE SIGNED <u>4-3-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M.D.</u>		ADDRESS (Street, city or town, state) <u>104 Bay Street, Snow Hill, Md.</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>	
22c. DATE THEREOF <u>April 4/59</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Gurns</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR <u>APR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04968

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Somerset Worc.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>#2 Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pocomoke City</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daisy</u> First <u>B.</u> Middle <u>Miles</u> Last		4. DATE OF DEATH <u>Apr.</u> Month <u>29</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22 1872</u> yrs. <u>86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marland</u>	
11. BIRTHPLACE (State or foreign country) <u>W D A</u>		12. CITIZEN OF WHAT COUNTRY? <u>W D A</u>	
13. FATHER'S NAME <u>Poulson, Miles</u>		14. MOTHER'S MAIDEN NAME <u>Sally Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>Harry B. Miles Upper Fairmount Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>422.1</u> DUE TO <u>Pulmonary oedema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degenerative Heart Disease, Atherosclerotic Years.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>9.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan.</u> , 1958, to <u>Apr. 9,</u> 1959, that I last saw the deceased alive on <u>Apr. 9,</u> 1959, and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4-10-59</u>			
ACTUAL SIGNATURE <u>Charles W. Trader</u> M.D.		4-10-59	
PHYSICIAN'S NAME (Type) <u>Charles W. Trader, M.D.</u>		<u>302 Market St., Pocomoke City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Apr 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Miles Family Cemetery Upper Fairmount Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry B. Miles Upper Fairmount</u> ADDRESS		24a. REC'D BY REGISTRAR <u>APR 17 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Brown</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04969

Reg. Dist. No.

4980

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Stockton		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Rural - Stockton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #2				d. STREET ADDRESS RFD #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALVIN Middle FREDERICK Last MILLS				4. DATE OF DEATH Month April Day 24 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1957		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 24 Hours 19 Min.	IF UNDER 24 HRS. Months 2 Days 24 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Holden				14. MOTHER'S MAIDEN NAME Mary Hester Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mary Hester Mills, RFD 2, Stockton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably Pneumonia + Meningitis DUE TO Neglected Cold Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Infection Nose Throat + bronchitis DUE TO Parents rather delatatory in calling a doctor PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parents rather delatatory in calling a doctor							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Port II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE N. E. Sartorius				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Rural Stockton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR APR 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Krause			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Registrar		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Place		15. Signature of Cemetery		16. Signature of Funeral Home	
17. Signature of Mortician		18. Signature of Embalmer		19. Signature of Crematorium		20. Signature of Other	
21. Signature of Other		22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other		28. Signature of Other	
29. Signature of Other		30. Signature of Other		31. Signature of Other		32. Signature of Other	
33. Signature of Other		34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other		40. Signature of Other	
41. Signature of Other		42. Signature of Other		43. Signature of Other		44. Signature of Other	
45. Signature of Other		46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other		52. Signature of Other	
53. Signature of Other		54. Signature of Other		55. Signature of Other		56. Signature of Other	
57. Signature of Other		58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other		64. Signature of Other	
65. Signature of Other		66. Signature of Other		67. Signature of Other		68. Signature of Other	
69. Signature of Other		70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other		76. Signature of Other	
77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other		88. Signature of Other	
89. Signature of Other		90. Signature of Other		91. Signature of Other		92. Signature of Other	
93. Signature of Other		94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sturdlitice</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sturdlitice</u>	
c. LENGTH OF STAY IN 1b <u>70 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>J.</u> Last <u>Pilchard</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17 - 1888</u>
9. AGE in years <u>71</u> Months <u>0</u> Days <u>25</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Washington Pilchard</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hancock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William B. Pilchard, Sturdlitice, Md</u>		18. ADDRESS <u>Sturdlitice, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>10 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POLYCYSTIC RENAL DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1954, to <u>April 12</u> , 1959, that I last saw the deceased alive on <u>April 12</u> , 1959, and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		DATE SIGNED <u>4-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>		<u>Snow Hill, Md.</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sturdlitice, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Thomas</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2nd Class

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1880"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "10/20/1920"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CLERK [Faint signature]	

NO CONTENT

RECEIVED



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4982

CERTIFICATE OF DEATH

04971

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1		d. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First BETH Middle JEAN Last PURWELL		4. DATE OF DEATH Month 4 Day 18 Year 1959	
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-59
9. AGE (In years last birthday) yrs. 15		IF UNDER 1 YEAR Months 15 Days min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY BATES		14. MOTHER'S MAIDEN NAME SARAH E. PURWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. MISS SARAH PURWELL, NEWARK, MD, RT #2	
17. INFORMANT MISS SARAH PURWELL, NEWARK, MD, RT #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal death 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asphyxia DUE TO (c) Obstruction of airways		INTERVAL BETWEEN ONSET AND DEATH 15min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md	
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.		DATE SIGNED 4/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-20-59	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN, CEMETERY		22d. LOCATION (City, town, or county) (State) Berlin Md	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart		ADDRESS Flower Home, Salisbury, Md	
24a. REC'D BY REGISTRAR APR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thane	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5000201XV5

CERTIFICATE OF DEATH

04972

Reg. Dist. No.

4983

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Avenue</u>				d. STREET ADDRESS <u>Maple Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>John A. Purnell</u>				4. DATE OF DEATH <u>April 27 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Purnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Lina Jacobs</u> Address <u>Maple St. Berlin MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rt lower lip</u> <u>140.1</u> DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-5</u> , 19 <u>56</u> , to <u>4-20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-20</u> , 19 <u>59</u> , and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sulky, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u>			
PHYSICIAN'S NAME (Type) <u>Ivory U. Sulky, Jr. M.D.</u>				DATE SIGNED <u>4/29/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/30/ 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kneass</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1983

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
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37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
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43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
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49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
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79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4984

CERTIFICATE OF DEATH

Reg. Dist. No.

04973

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>				c. LENGTH OF STAY IN 1b <u>6 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1 ST. LOUIS AVE</u>			
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>Bowers</u> Middle <u>Reeder</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 16, 1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>OWING MILLS, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>WILLIAM R BOWERS</u>			
14. MOTHER'S MAIDEN NAME <u>LILLIAN SLOFFER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>578-16-3960</u>				17. INFORMANT Address <u>MRS. LEONARD BUVELL OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO <u>Arterio sclerotic cerebral vasculopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 year.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>58</u> , to <u>Apr 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 25</u> , 19 <u>59</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>Ocean City, Md</u> DATE SIGNED <u>April 27, 59</u>			
PHYSICIAN'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>4/28 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Surbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4985

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X New ark (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Flower Street			d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) George Henry Spence			4. DATE OF DEATH 4 25 19 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1940		9. AGE (In years last birthday) 19 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursery		10b. KIND OF BUSINESS OR INDUSTRY Planting		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Wesley Johnson		
14. MOTHER'S MAIDEN NAME Evelyn Spence			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Evelyn Spence, Newark, Md Rt #1		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431X Acute Cardiac Failure DUE TO (b) Myocarditis, Acute DUE TO (c) Undetermined					INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Edema					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Herman A. Robbins		EXAMINER'S NAME (Type) Herman A. Robbins, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Chapel Cemetery	
22d. LOCATION (City, town, or county) Newark, Maryland		22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, if possible, to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4882

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-17-24

PLACE IN DEATH
ACCOUNT

1. NAME OF DECEASED: John Doe

2. SEX: Male

3. AGE: 45

4. OCCUPATION: Teacher

5. PLACE OF BIRTH: John Doe

6. DATE OF BIRTH: 11-17-24

7. TIME OF DEATH: 11:00 AM

8. CAUSE OF DEATH: Heart Disease

9. MANNER OF DEATH: Natural

10. SIGNATURE OF MEDICAL EXAMINER: John Doe

11. SIGNATURE OF DEATH REGISTRAR: John Doe

12. SIGNATURE OF CLERK: John Doe

13. SIGNATURE OF JURY: John Doe

14. SIGNATURE OF JUDGE: John Doe

15. SIGNATURE OF DISTRICT ATTORNEY: John Doe

16. SIGNATURE OF SHERIFF: John Doe

17. SIGNATURE OF CORONER: John Doe

18. SIGNATURE OF JAILER: John Doe

19. SIGNATURE OF PRISON WARDEN: John Doe

20. SIGNATURE OF CHIEF OF POLICE: John Doe

21. SIGNATURE OF CHIEF OF FIRE DEPARTMENT: John Doe

22. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT: John Doe

23. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT: John Doe

24. SIGNATURE OF CHIEF OF MENTAL HOSPITAL: John Doe

25. SIGNATURE OF CHIEF OF EYE HOSPITAL: John Doe

26. SIGNATURE OF CHIEF OF EAR, NOSE AND THROAT HOSPITAL: John Doe

27. SIGNATURE OF CHIEF OF DENTAL HOSPITAL: John Doe

28. SIGNATURE OF CHIEF OF DISPENSARY: John Doe

29. SIGNATURE OF CHIEF OF PHARMACY: John Doe

30. SIGNATURE OF CHIEF OF LABORATORY: John Doe

31. SIGNATURE OF CHIEF OF X-RAY DEPARTMENT: John Doe

32. SIGNATURE OF CHIEF OF RADIOLOGICAL DEPARTMENT: John Doe

33. SIGNATURE OF CHIEF OF PATHOLOGICAL DEPARTMENT: John Doe

34. SIGNATURE OF CHIEF OF BACTERIOLOGICAL DEPARTMENT: John Doe

35. SIGNATURE OF CHIEF OF VIROLOGICAL DEPARTMENT: John Doe

36. SIGNATURE OF CHIEF OF SEROLOGICAL DEPARTMENT: John Doe

37. SIGNATURE OF CHIEF OF IMMUNOLOGICAL DEPARTMENT: John Doe

38. SIGNATURE OF CHIEF OF ANATOMICAL DEPARTMENT: John Doe

39. SIGNATURE OF CHIEF OF PHYSIOLOGICAL DEPARTMENT: John Doe

40. SIGNATURE OF CHIEF OF PSYCHOLOGICAL DEPARTMENT: John Doe

41. SIGNATURE OF CHIEF OF PSYCHIATRIC DEPARTMENT: John Doe

42. SIGNATURE OF CHIEF OF NEUROLOGICAL DEPARTMENT: John Doe

43. SIGNATURE OF CHIEF OF ORTHOPAEDIC DEPARTMENT: John Doe

44. SIGNATURE OF CHIEF OF SURGICAL DEPARTMENT: John Doe

45. SIGNATURE OF CHIEF OF MEDICAL DEPARTMENT: John Doe

46. SIGNATURE OF CHIEF OF DERMATOLOGICAL DEPARTMENT: John Doe

47. SIGNATURE OF CHIEF OF Gynaecological DEPARTMENT: John Doe

48. SIGNATURE OF CHIEF OF PEDIATRIC DEPARTMENT: John Doe

49. SIGNATURE OF CHIEF OF INFANT MORTALITY DEPARTMENT: John Doe

50. SIGNATURE OF CHIEF OF MATERNAL MORTALITY DEPARTMENT: John Doe

51. SIGNATURE OF CHIEF OF TUBERCULOSIS DEPARTMENT: John Doe

52. SIGNATURE OF CHIEF OF SYPHILIS DEPARTMENT: John Doe

53. SIGNATURE OF CHIEF OF GONORRHOEA DEPARTMENT: John Doe

54. SIGNATURE OF CHIEF OF VENEREAL DISEASES DEPARTMENT: John Doe

55. SIGNATURE OF CHIEF OF SCURVY DEPARTMENT: John Doe

56. SIGNATURE OF CHIEF OF RICKETS DEPARTMENT: John Doe

57. SIGNATURE OF CHIEF OF BERBERI DEPARTMENT: John Doe

58. SIGNATURE OF CHIEF OF MALARIA DEPARTMENT: John Doe

59. SIGNATURE OF CHIEF OF FEVER DEPARTMENT: John Doe

60. SIGNATURE OF CHIEF OF COUGHS DEPARTMENT: John Doe

61. SIGNATURE OF CHIEF OF BRONCHITIS DEPARTMENT: John Doe

62. SIGNATURE OF CHIEF OF ASTHMA DEPARTMENT: John Doe

63. SIGNATURE OF CHIEF OF PNEUMONIA DEPARTMENT: John Doe

64. SIGNATURE OF CHIEF OF TUBERCULOSIS DEPARTMENT: John Doe

65. SIGNATURE OF CHIEF OF LUNG DISEASES DEPARTMENT: John Doe

66. SIGNATURE OF CHIEF OF HEART DISEASES DEPARTMENT: John Doe

67. SIGNATURE OF CHIEF OF BLOOD DISEASES DEPARTMENT: John Doe

68. SIGNATURE OF CHIEF OF SKIN DISEASES DEPARTMENT: John Doe

69. SIGNATURE OF CHIEF OF EYE DISEASES DEPARTMENT: John Doe

70. SIGNATURE OF CHIEF OF EAR, NOSE AND THROAT DISEASES DEPARTMENT: John Doe

71. SIGNATURE OF CHIEF OF DENTAL DISEASES DEPARTMENT: John Doe

72. SIGNATURE OF CHIEF OF PHARYNGEAL DISEASES DEPARTMENT: John Doe

73. SIGNATURE OF CHIEF OF LARYNGEAL DISEASES DEPARTMENT: John Doe

74. SIGNATURE OF CHIEF OF TRACHEAL DISEASES DEPARTMENT: John Doe

75. SIGNATURE OF CHIEF OF BRONCHIAL DISEASES DEPARTMENT: John Doe

76. SIGNATURE OF CHIEF OF PULMONARY DISEASES DEPARTMENT: John Doe

77. SIGNATURE OF CHIEF OF PERICARDIAL DISEASES DEPARTMENT: John Doe

78. SIGNATURE OF CHIEF OF MYOCARDIAL DISEASES DEPARTMENT: John Doe

79. SIGNATURE OF CHIEF OF ENDOCARDIAL DISEASES DEPARTMENT: John Doe

80. SIGNATURE OF CHIEF OF VALVULAR DISEASES DEPARTMENT: John Doe

81. SIGNATURE OF CHIEF OF CONDUCTIVE SYSTEM DISEASES DEPARTMENT: John Doe

82. SIGNATURE OF CHIEF OF CIRCULATORY SYSTEM DISEASES DEPARTMENT: John Doe

83. SIGNATURE OF CHIEF OF RESPIRATORY SYSTEM DISEASES DEPARTMENT: John Doe

84. SIGNATURE OF CHIEF OF DIGESTIVE SYSTEM DISEASES DEPARTMENT: John Doe

85. SIGNATURE OF CHIEF OF URINARY SYSTEM DISEASES DEPARTMENT: John Doe

86. SIGNATURE OF CHIEF OF REPRODUCTIVE SYSTEM DISEASES DEPARTMENT: John Doe

87. SIGNATURE OF CHIEF OF ENDOCRINE SYSTEM DISEASES DEPARTMENT: John Doe

88. SIGNATURE OF CHIEF OF IMMUNE SYSTEM DISEASES DEPARTMENT: John Doe

89. SIGNATURE OF CHIEF OF NERVOUS SYSTEM DISEASES DEPARTMENT: John Doe

90. SIGNATURE OF CHIEF OF MUSCULOSKELETAL SYSTEM DISEASES DEPARTMENT: John Doe

91. SIGNATURE OF CHIEF OF INTEGUMENTARY SYSTEM DISEASES DEPARTMENT: John Doe

92. SIGNATURE OF CHIEF OF SENSORY SYSTEM DISEASES DEPARTMENT: John Doe

93. SIGNATURE OF CHIEF OF MOTOR SYSTEM DISEASES DEPARTMENT: John Doe

94. SIGNATURE OF CHIEF OF PSYCHIC SYSTEM DISEASES DEPARTMENT: John Doe

95. SIGNATURE OF CHIEF OF BEHAVIORAL SYSTEM DISEASES DEPARTMENT: John Doe

96. SIGNATURE OF CHIEF OF SOCIAL SYSTEM DISEASES DEPARTMENT: John Doe

97. SIGNATURE OF CHIEF OF CULTURAL SYSTEM DISEASES DEPARTMENT: John Doe

98. SIGNATURE OF CHIEF OF ECONOMIC SYSTEM DISEASES DEPARTMENT: John Doe

99. SIGNATURE OF CHIEF OF POLITICAL SYSTEM DISEASES DEPARTMENT: John Doe

100. SIGNATURE OF CHIEF OF LEGAL SYSTEM DISEASES DEPARTMENT: John Doe

CERTIFICATE OF DEATH

Reg. Dist. No.

04975

4986

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. LENGTH OF STAY IN 1b 76			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1 Bay St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last BRUCE HENRY WALSTON				4. DATE OF DEATH Month Day Year APRIL 8 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 9, 1882	
9. AGE (In years lost birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSEMYMAN				10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) BERLIN MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EBENEZER WALSTON				14. MOTHER'S MAIDEN NAME DELLA HOUSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address MR. STANLEY DAILEY BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of gall bladder or pancreas? DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 5, 1959 to April 11, 1959 , that I last saw the deceased alive on 4/8/59 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) BERLIN, MD. DATE SIGNED 4-9-59							
ACTUAL SIGNATURE Robert A. Grubb, M.D.				PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/59		22c. NAME OF CEMETERY OR CREMATORY BERKIN CEM		22d. LOCATION (City, town, or county) (State) Berlin Md	
23. FUNERAL DIRECTOR'S SIGNATURE Anne A. Burboys Berlin Md				24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04976

Reg. Dist. No.

4987

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elias</u> Middle <u>Widie</u> Last <u>Widie</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>NOVA MESTO, SOFOSLAVIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mrs. Frank Widie</u>		Address <u>Berlin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sunshot wounds of Brain</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tied 410 Shotgun to Fence - Pulled trigger and began</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:30 P.M. 4-15-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At own home</u>		20f. (City or town) (County) (State) <u>Berlin Worcester Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-17-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Burby</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

